

# NO EASY ANSWERS

BY KAREN BENDER

## Is There a Future for

“**H**ealth Coverage Continues Decline.” “Employment-Based Coverage Drops.” These are typical of the headlines and articles prevalent in the

news today. In a “normal” market, the erosion of one source of supply would enhance the opportunities of other suppliers. So if employment-based coverage drops, this means that there will be an increased demand for individual insurance, right? As any health actuary who has been in the business for long knows, health insurance is not a “normal” market, and a drop in the employment-based health insurance market may or may not bode well for individual health insurance.

The real underlying problem to the health insurance “crisis” is that health care is extremely expensive. I want to say upfront that I don’t have any easy answers to this. Easy answers would already have been identified and implemented. Even so, the issues facing the individual health insurance market are real and merit discussion.

Why doesn’t the drop in employment-based coverage bode well for individual insurance? First, the drop will increase the focus on the individual market, and it may not be able to bear the scrutiny. Individuals used to obtaining insurance through their employers will expect access, affordability, and portability. Will they find it?

Second, in the employment-based market, the employer makes a significant contribution to premiums, thus shielding the employee from the true cost of insurance. In the existing individual insurance market, the individual pays 100 percent of the premium, resulting in sticker shock for many considering its purchase.

Third, acquisition and ongoing administrative expenses are significantly higher for individual health insurance than they are for the small-employer and large-employer counterparts. While we in the industry understand these costs, will we be able to defend 60 cents to 75 cents of every premium dollar going toward claims as opposed to 80 cents to 90 cents in the group market? Or, conversely, 25 to 40 cents of every premium dollar going toward retention?

**As more and more employers drop their health insurance coverage, will individual coverage be able to fill the gap?**

### State of the States

According to the 2005 Employer Health Benefits Summary, published by the Kaiser Family Foundation and Health Research and Education Trust, employment-based insurance dropped from 69 percent to 60 percent in the past five years. Some of the causes are:

- Group insurance premiums are increasing at rates that are multiples of the general cost-of-living increases as well as wage increases.
- Fewer small employers offer insurance. (Sixty-two percent of all uninsured workers were either self-employed or working for firms with fewer than 100 employees. And 35 percent of workers employed with firms with fewer than 10 employees were uninsured.)
- An increasing number of employers are asking their employees to contribute more to the cost of health insurance premiums. The take-up rate (the percentage of employees opting for insurance when offered) decreased from 87 percent in 1997 to 84.8 percent in 2002.
- Of those who didn’t elect to participate in their own employers’ health plan, 71.3 percent (up from 64.4 percent) cited cost as the reason.
- Employers are dropping insurance programs for early retirees. And what are states doing to stop the erosion in the employer market?
- Some states are considering employer mandates (pay or play) as well as individual mandates.
- Other states are trying to tax large employers that don’t spend enough of their payroll on health benefits, the theory being that some of those employees not receiving health insurance benefits will end up on the Medicaid rolls. This is commonly known as the

# Individual Health Insurance



“anti-Wal-Mart” approach, and it recently prevailed

over a gubernatorial veto in Maryland.

■ Some are changing the definition of “dependent” to enable young adults to continue coverage under their parents’ policy. New Jersey lawmakers recently approved a bill requiring health insurers to provide the dependent coverage option for dependents up to age 30! It doesn’t appear that the New Jersey bill even requires that young adults be dependents in the traditional sense, only that they’re unmarried without dependents of their own and that they’re not insured.

■ Almost all states have expanded Medicaid-type programs, such as the State Children’s Health Insurance Program (SCHIP) to insure children (and sometimes adults) of low-income families.

■ Some states are studying the possibility of introducing a single-payer system.

## Lessons From Small-Employer Groups

It’s interesting to note that these state efforts appear to acknowledge that the individual market isn’t a viable alternative to the absence of employer-sponsored insurance, or there wouldn’t be so many efforts to maintain the employer-sponsored health insurance paradigm. This observation by itself indicates that the individual market may be the next target for increased regulatory focus, especially if there is a general belief that the existing market isn’t meeting the needs of the public.

What can we learn from the small-employer group market? First, I want to emphasize that individual insurance is very dif-

ferent from group insurance; a pool composed of individuals is different from a pool composed of many small employers. There are, however, some things we can learn from the reforms that occurred in the small-group market. The main issues that drove small-employer group reform in the early 1990s were access, affordability, and portability. The Health Insurance Portability and Accountability Act (HIPAA) with its portability rules and guaran-

teed-issue requirement for all employers with between two and 50 employees, eliminated the access-and-portability issue for small employers and their employees.

Affordability remains a problem for small employers. In my opinion, the cost of guaranteed issue in a voluntary insurance market was significantly more than any of us anticipated. I conclude this because premium trends in the small-group market have consistently been percentage points higher than the premium trends in the large-group market over the same periods. If the cost of guaranteed issue was a one-time occurrence, then we should have observed an increase in the initial year or so after HIPAA implementation. Then the trends for the two markets should have been consistent. This becomes important when we study the issue for the individual market.

## Access

In most states, carriers in the individual market are allowed to vary premiums by age, gender, geography, and smoking status. Traditionally, potential buyers in the individual market must pass medical health underwriting in order to purchase insurance. Insurance companies generally have the following choices: accept the individual; accept the individual with riders for specific conditions; reject the individual. Sometimes companies will implement a surcharge to the premium in lieu of riders. Pre-existing condition clauses are present in almost all individual policies (other than those that are HIPAA-eligible).

## EARLY RETIREES, WHO NO LONGER HAVE ACCESS TO EMPLOYER-BASED INSURANCE COVERAGE, ARE SHOCKED AT THEIR INABILITY TO PURCHASE AFFORDABLE HEALTH INSURANCE.

According to a study completed by America's Health Insurance Plans (AHIP), about 88 percent of applicants in the individual market were offered coverage. However, the offer rates varied significantly by age, with 95 percent of the applicants under the age of 18 being offered coverage and only 70 percent of the applicants ages 60 to 64 being offered coverage.

The study also shows that the number of applicants ages 60 to 64 was significantly less than the number of applicants at younger ages, which could indicate that the older individuals with health conditions didn't apply for insurance—whether discouraged from applying or not actively marketed to.

Of the 88 percent of applicants who were offered coverage, slightly more than three-quarters were offered standard rates; about 22 percent were offered higher premiums, and the balance were offered waivers, higher premiums and waivers, or some other combinations.

Once again, the percentages vary significantly by age. About 87 percent of the applicants under age 18 accepted for coverage were offered standard premiums, while about 56 percent of applicants accepted for coverage at ages 60 to 64 were offered standard premiums. About 40 percent of applicants accepted for coverage in the 60 to 64 age group were offered higher premiums, and the balance were offered some combination of higher premiums and/or waivers.

Of the total number of applicants ages 60 to 64, 30 percent were rejected; about 39 percent were offered coverage at standard rates; 28 percent were offered coverage at higher premium rates, and the balance were offered coverage at some combination of higher rates and waivers.

Remember, older individuals' standard premiums are higher than the standard premiums for younger individuals to reflect the higher cost of health claims as we all age. So a load to a standard premium for individuals ages 60 to 64 is above and beyond the incremental cost for expected aging.

Why is this important? Because employment-based insurance is eroding and because the baby boomers are aging and retiring (some by choice and some by other means). Early retirees, who no longer have access to employer-based insurance coverage, are shocked at their inability to purchase affordable health insurance.

A study by the California HealthCare Foundation found that heads of families age 55 and over, many of whom are early retirees, are more than twice as likely to purchase individual insurance as those under age 35. Yet, according to the AHIP survey, the number of applications for this category was significantly lower than the number of applications for younger people.

Is something occurring in the marketplace to discourage older individuals from even applying for insurance? Also, we baby boomers are not an "accepting" pool; we'll complain loudly and often when we discover that we can't easily access insurance coverage, and the one thing that regulators don't like is complaints.

### **Affordability**

The second issue that drove reform in the small-group market was affordability. The resulting reforms limited the amount of variation carriers could charge one employer versus another employer. The National Association of Insurance Commissioners (NAIC) developed several model bills describing what it considered to be reasonable rate reforms. Each state then decided what type of rating rules best fit its needs, with the results ranging from pure community rating to no rating limits whatsoever. Community rating means that rates can vary only by dependent status (e.g., single, family) within a given geographic area for a specific benefit. Other factors such as age, gender, group size, industry, morbidity, and/or health status can't be used to determine initial or renewal rates.

The result is a complex set of regulations with no nationwide consistency. While these reforms did succeed in reducing the variation in rates among employer groups within a specific state, they haven't been successful in controlling the overall costs of health insurance and may have exacerbated the affordability problem.

Some states tried to carry over the small-group reforms into the individual market. Be careful what you wish for; the resulting experience in the individual markets from some of these reforms has been less than stellar.

New Jersey implemented guaranteed issue, community rating, and standardized plans in its nongroup market from 1992 to 1994. Premiums have increased well above the rest of the country. As of June 2005, the lowest annual premium a family could pay for a \$500 deductible plan was \$46,944—and as high as \$263,904. Few would argue that these premiums are affordable.

Vermont, New York, and New Hampshire also implemented pure community rating and guaranteed issue for the individual market during this same period. Kentucky, Washington, Massachusetts, and Maine implemented modified community rating and some form of guaranteed issue. The results have been consistent: A large number of carriers have withdrawn from the individual market, leaving consumers with significantly fewer choices. By 1996, there was only one carrier in Kentucky that was still in the individual health insurance market. There were none in Washington at one time.

Premiums have risen significantly above the increases observed in other states. A study completed in 2002 showed that Massachusetts, New York, New Hampshire, and New Jersey, four of the states that passed the most rigorous individual health insurance reforms, had the four highest annual insurance premiums for individual family coverage in the country.

There have been different reactions to the adverse impacts in these states. New Hampshire and Kentucky have been trying to "reverse" the reforms and introduce provisions that would make these states more similar to the environment in non-reform states. They've discovered, however, that it's easier to get insurance companies to leave the state than it is to have them return.

Vermont expanded its Medicaid eligibility, in part to address the exodus of carriers, and is now second in the nation in the proportion of its under-65 population covered by Medicaid.

New York introduced Healthy New York, a state-subsidized program targeted at low-income individuals and small employers. Washington and New Jersey have implemented a series of “reforms of the reform” in efforts to mitigate the adverse consequences of their initial good intentions. Maine has introduced the state-sponsored Dirigo Health Plan, intended to eliminate the 136,000 uninsured within six years with a reduction of 57,000 within the first year. Enrollment during the first year was 7,300, of which fewer than 2,000 were formerly uninsured. What did increase in Maine was enrollment in MaineCare, Maine’s Medicaid program, which now insures nearly 25 percent of Maine’s population.

Can a private insurance industry survive as the primary source of insurance when so many are enrolled in public programs?

The previous examples show how good intentions resulted in exactly the opposite results. However, the industry also needs to be cognizant of some of its own practices that drive the pressure for some of these regulations.

Many insurance companies use associations (or some similar enabling vehicle such as discretionary trusts) to market what is, for all practical purposes, individual insurance. These vehicles are classified as “group” insurance in some states and allow insurance companies to bypass the rate approval processes (and sometimes other regulatory oversight) required of traditional individual policies.

This can be an asset in the market by providing a more efficient means of delivering health insurance, but it can also be abused. Not so long ago, the *Wall Street Journal* reported on an insurer using health status and/or claim experience to set renewal rates for each individual without any reasonable ceiling. While the use of health status and/or claim experience may be a valid means of maintaining a viable individual pool, there must be reasonable limits.

Another approach in the individual market is to introduce a set of products for several years and then “close the pool” and start a new pool with a new set of products. No new members can enter the closed pool, and only those who can pass health underwriting are allowed into the new pool. The rate for each pool is based solely on the experience of that particular pool. The average morbidity in the old pool can only deteriorate, resulting in higher-than-trend increases. The individuals in the old pool who can pass health underwriting have an incentive to join the new pool because of lower rates. There are fewer members in the old pool to spread the risk. The results are escalating premiums in the old pool.

As someone who reviews rate filings for various states, I’ve observed first hand the premium level that can result from these closed pools. The closed-pool problem was the subject of an intense five-year study completed by an Academy committee (of which I was a member) on the behalf of the NAIC. Because of NAIC direction, experience rating (e.g., the use of health status and/or claim experience to determine, in part, renewal rates) wasn’t one of the scenarios studied. The NAIC is currently considering which, if any, of the proposed possible “solutions” modeled by the Academy it will adopt.

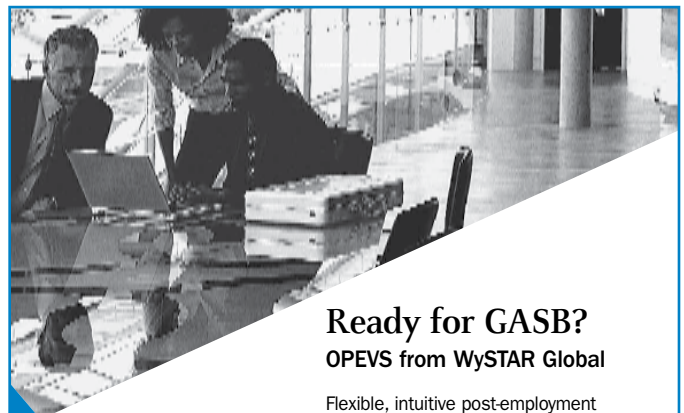
Durational rates are another technique for attracting the best new business. Besides using open and closed pools, insurers can vary the rates within a pool by year of issue as underwriting wears off. If used appropriately, this may be a way of creating a viable pool over the long run. If abused, the practice could be considered “bait and switch” where the rates are very low initially and increase significantly when the impacts of underwriting no longer apply.

If the industry doesn’t want what it considers to be unreasonable regulations, it needs to discipline itself to avoid the circumstances that drive the regulations.

### Portability

Portability is defined as the ability to change carriers without having to undergo medical underwriting or satisfy any pre-existing-condition waiting periods. HIPAA guarantees portability between employer group plans as well as between employer group plans to individual plans. HIPAA didn’t address premium rates, however. So while coverage for an individual transferring from a qualified group plan to an individual plan was guaranteed coverage, the premium rates could still be very high.

States that have implemented guaranteed issue with no (or minimal) pre-existing condition limitations in their individual market have, by default, introduced portability. The previous examples of the adverse effects of guaranteed issue in the individual market demonstrate that this is not a solution. We all know that the industry can’t survive “just-in-time” insurance. Washington tried this with its reforms and drove all carriers out of the market.



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## The Future

We have numerous examples of reforms that don't work. We also know that the status quo will only invite more regulatory oversight, which could have results exactly the opposite of those intended. It appears that the current system can't adequately meet the needs of a large population that may be required to seek insurance on an individual basis.

How do we handle the portability problem? I had the opportunity to participate in the Academy's visits to Capitol Hill last year, where I talked to legislators who can't understand why individual insurance shouldn't have the same portability requirements as group insurance. It's a challenge trying to explain how this isn't easily accomplished in a voluntary individual market where the financial incentive would be to insure the medically underwritten individuals for the first couple of years and then encourage them to leave thereafter.

I don't think I was able to make them understand that there's no easy way to achieve portability without significantly increasing the cost and complexity of insurance and its administration.

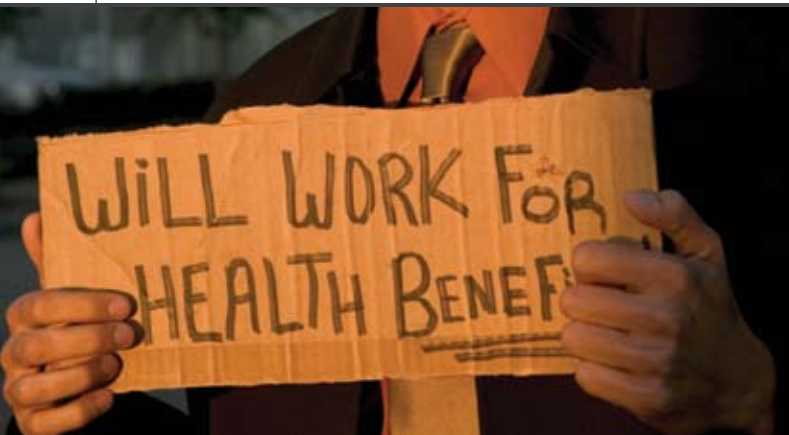
health insurance market where even the sick can purchase insurance at what is perceived as reasonable rates. The Bush administration is working hard on extending tax incentives for individual health insurance that will be closer to or at the same level as those enjoyed by employers. If this is successful, then the scrutiny of the weaknesses of the individual market will increase.

Will there be an effort to define national standards for the individual health insurance market (similar to a federal charter) to eliminate the costs of trying to comply with 50 different departments of insurance? If so, what will these national standards look like?

What about an individual mandate? This undoubtedly would increase demand for increased access. Is the industry ready?

As I said before, I don't have answers to all these questions. I do know, however, that if the industry wants to control its own destiny, it needs to consider some of its existing practices and try to develop solutions proactively. ●

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THERE'S NO EASY WAY TO ACHIEVE PORTABILITY WITHOUT SIGNIFICANTLY INCREASING THE COST AND COMPLEXITY OF INSURANCE AND ITS ADMINISTRATION.

If the individual market is to be viewed as a viable alternative to group insurance, there is going to be tremendous pressure to increase the number of applicants ages 50 to 64, as well as to improve the acceptance ratio for this population and the population as a whole. While high-risk pools, which exist in many states, serve as a safety net for the truly uninsurable, the high premium associated with these pools creates an affordability barrier.

Expanding the acceptance rate can be an opportunity for the industry to develop new and innovative underwriting/rating approaches, such as conditioning renewal rates upon acceptable blood pressure readings, compliance with medical protocols and disease management programs, etc. This approach will also require flexibility by regulators.

High-deductible health plans and health savings accounts are ideal for the individual market and may represent the first step toward employers shedding their health insurance obligations. The biggest barrier to employers adopting a defined contribution approach to health insurance is the absence of a viable individual

## Resources

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